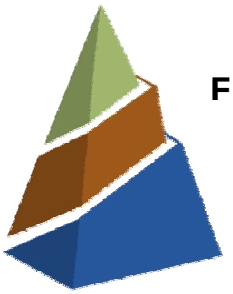

FINANCIAL SERVICES ASSESSMENT

Microinsurance - Exploring Ways to Assess its Impact

PAMELA YOUNG
MICROFINANCE OPPORTUNITIES

June 2006

Financial Services Assessment project can be found on the web at
http://www.fsassessment.umd.edu/

ABOUT THE PROJECT

The *Assessing the Impact of Innovation Grants in Financial Services* project is designed to examine the impact of financial services on the lives of poor people across the developing world. This project is funded by the Bill & Melinda Gates Foundation, which is committed to building a deep base of knowledge in the microfinance field. The IRIS Center at the University of Maryland, College Park, together with its partner Microfinance Opportunities, will assess a diverse range of innovations in financial services. The results of this project will shed light on the design and delivery of appropriate financial products and services for the poor, and the potential to scale up successful innovations to reach larger numbers of low-income households.

FUNDING

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REPORT SERIES

This report is part of a series that will be generated by the *Assessing the Impact of Innovation Grants in Financial Services* project. The reports are disseminated to a broad audience including microfinance institutions and practitioners, donors, commercial and private-sector partners, policymakers, and researchers.

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Pam Young carried out the field research in Uganda with the assistance of consultants, Peter Mukwana and Edward Kiyaga.

ABSTRACT

The purpose of this study was to identify and refine indicators that can be used to assess the impact of microinsurance on the poor. Specifically, it examined changes in household financial behavior and risk coping strategies among insurance policyholders compared to non-policyholders.

The research methods consisted of focus group discussions with members of FINCA Uganda, Save for Health Uganda, and two groups of non-members (one rural, one urban), in addition to individual interviews with key informants. This study relied on qualitative techniques. While the results cannot be generalized, they do indicate areas of potential impact of insurance, and will be used to inform the design of future studies on the impact of microinsurance.

Respondents with health coverage, through either microinsurance or emergency credit, were more likely to report seeking medical treatment early on and following the full and appropriate course of treatment than respondents without cover. Insurance policy holders also indicated an increased feeling of safety and a greater likelihood of taking preventative health precautions, such as boiling water. Health insurance was also said to help decrease the financial burden associated with a health shock. Customers of FINCA's group-accident policy did not report behavior changes. This may be due to the short policy term, which was limited to the loan term, and to the fact that many FINCA clients lacked knowledge of this product.

Current measures for assessing the impact of microfinance, especially credit, are inadequate to assess microinsurance. Microinsurance has a particular effect on client attitude and behavior. While it is difficult to measure the extent to which microinsurance can impact a client's sense of security, behavioral changes, such as seeking health treatment early on, can be assessed. It is also essential to consider how the client's knowledge and awareness of the insurance product affects its impact on the client, such as in FINCA's group accident policy. Finally, assessment techniques and the indicators used to measure the impact of microinsurance need to take into consideration the variability of types of insurance products available.

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I. Introduction

Over the past decade, a number of microfinance institutions (MFIs) and other organizations have begun providing insurance for the poor. Known collectively as microinsurance, these new financial products seek to help the poor by reducing their vulnerability to unexpected shocks like illness or death. Whether and how they actually do help the poor, however, is up for debate. To date, no study has documented the impact of microinsurance on the welfare of low-income individuals. Indeed, because the field of microinsurance is still new, it is not even clear where to look for the impact. Although numerous studies have sought to assess the impact of micro-credit and savings by measuring changes in indicators such as household income and expenditures, whether these same indicators apply to microinsurance is unknown.

This study aims to contribute to the field of microfinance by identifying and refining indicators that can be used to study the impact of microinsurance. It explores how household financial behavior may change as a result of purchasing insurance and compares how those with insurance (or policyholders) cope with risks differently from those without insurance (or non-policyholders). In doing so, the study takes a first step toward identifying areas or "domains" of impact that can be expected to change as a result of having insurance. The goal is to have the results of this study feed into the design of a longer-term, more comprehensive impact assessment of microfinance.

This paper begins with a description of a preliminary causal model that presents several hypotheses regarding impact of microinsurance. The model outlines the pathways by which insurance is believed to benefit the poor, based on existing literature. The causal model is a conceptual framework that examines how access and use of financial products can lead to impact. It also identifies the domains of impact and their corresponding sets of indicators. After describing the preliminary causal model and a preliminary set of impact indicators specific to microinsurance in Section Two, Section Three presents the objectives and research questions for this study. Section Four describes the methodology and data collection, and Section Five presents the main findings. The last two sections summarize the main conclusions and suggest a set of research questions for further study.

II. Background

The concept of insurance for the poor is not new. Low-income communities in different parts of the world have relied on informal group-based mechanisms like savings clubs and burial societies to protect themselves against losses due to adverse shocks. Some countries also experimented with government-backed crop insurance schemes in the 1970s and 1980s. What's new is the introduction of "microinsurance." Inspired by the success of the micro-credit movement, a handful of insurance companies, MFIs, and other organizations are now experimenting with new ways to deliver insurance to the poor. Started only in the mid- to late-1990s, microinsurance represents a new and emerging area within the field of microfinance.

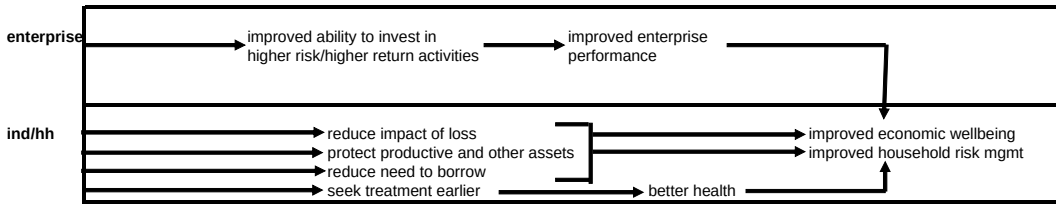
The Bill and Melinda Gates Foundation is interested in measuring the impact of innovations – including insurance – in microfinance through a long-term impact assessment. As part of an effort to prepare for and design this assessment, Microfinance Opportunities undertook a short field study in June 2006 to determine the dimensions of a preliminary causal model that seeks to explain how insurance could lead to a reduction in poverty.

CAUSAL MODEL AND INDICATORS

Traditionally, impact assessments have assumed that impacts simply occur, without asking how they occur. In particular, they have not asked: 1) how do the poor use financial services and 2) how does the use of microfinance services affect the impact on the client, his/her household, and his/her enterprise? Use is one critical component to understanding the relationship between product and impact. The use of a product reflects its relevance to the client and reveals the appropriateness of its design. How a client uses a product will also affect the way in which impacts can occur and ultimately the impacts themselves. By following the use of the financial services, one can identify the causal flows that determine if – and how – financial services achieve impact.

For the Gates Foundation-funded impact assessment of microfinance, the IRIS/Microfinance Opportunities team developed a preliminary causal model based on existing literature that links use to impact. The following chart is a graphic representation of this preliminary causal model for insurance only. The arrows represent the causal flows that lead from use of microinsurance to its impact on the individual/household and a person's enterprise. They show the links between intermediate and final impacts as well as their sequencing.

FIGURE 1: PRELIMINARY IMPACT CASUAL MODEL OF INSURANCE



In the preliminary causal model for insurance, there are four domains or areas of impact: enterprise performance, household wellbeing, household risk management,

and better health. The impact occurring within each of these domains is believed to occur via the following channels or causal pathways:

- Through insurance, individuals are better off because having insurance improves their ability to take on investments that involve more risk but higher returns, thereby improving the performance of their businesses/micro-enterprises and the wellbeing of their households.

- Those who suffer a sudden loss that is covered by insurance are better off because they are able to reduce the impact of that loss, protect their assets, and reduce their need to sell assets and to borrow.

- Those with health insurance have better health because they are able (and more willing) to seek treatment early and use preventive care.

The causal model for insurance impacts draws from a general framework developed by the IRIS/Microfinance Opportunities team to study the impact of various microfinance innovations. This framework ties together different levels of analysis (individual/client, household, enterprise, community and institution), the relevant domains of impact, and sets of indicators that correspond to the domains. The following is a table listing the domains and indicators that the IRIS/Microfinance Opportunities team has identified thus far. The indicators are the metrics by which changes within the domains can be measured.

The preliminary causal model and the framework are conceptual tools for designing a long-term impact assessment of microfinance. Because both draw from previous impact studies that don't take into account the new microinsurance products, it's not clear how well they can be applied to microinsurance. For example, can one measure the impact of microinsurance on an enterprise? Would one measure it in the same way one measures the impact of credit or savings? And are there other domains of impact and indicators that apply to microinsurance but are currently missing from these tools? This study seeks to address these and other related questions.

TABLE 1: FRAMEWORK FOR ASSESSING THE IMPACT OF INNOVATIONS IN FINANCIAL SERVICES

Level of Analysis	Domains of Impact	Indicators
Household	Risk management	Improved income smoothing Improved consumption smoothing Decreased cost of pre- or post-shock income smoothing
	Household economic wellbeing	Increased economic productivity Increased consumption of basic needs Increased household income Increased assets
	Poverty status	Reduced poverty
Client	Access to financial services	Increased options for financial products and services
	Use of financial services	More effective use of financial products and services
	Gender relations	Reduced gender inequality
Enterprise	Enterprise performance	Improved productivity Increased profitability Increased employment
	Enterprise assets	Increased financial assets Increased physical assets Increased human assets
	Enterprise upgrading	Adoption of new processes and technologies Adoption of new products Adoption of new value-added functions Sales to new market channels
Community	Social capital development	Increased social capital
	Community economic status	Increased employment at the community level Reduced cost of goods and services Increased participation of microenterprises in the value chain links to outside markets
Institution	Sustainability	Improved financial performance
	Scalability	Increased client outreach Increased client retention Increased geographic coverage

III. Research Objective and Key Questions

The objective of this study is to 1) verify the preliminary causal model for microinsurance and 2) identify and refine indicators that can be used to study the impact of microinsurance on the poor.

Specifically, the study addresses this objective by seeking to answer the following key questions:

- How do behaviors, knowledge, skills and attitudes differ between those with microinsurance and those without?
- How does microinsurance improve the ability of a household to smooth consumption and income?
- How does microinsurance change the ability of a household to withstand economic shocks?
- How does microinsurance protect the asset base of poor households and what is the effect of this protection?
- Is the enterprise level an appropriate area of impact? (i.e. does insurance lead to changes in productivity at the enterprise level? Should one expect to see changes in sales and profit?)

To answer the questions listed above, Microfinance Opportunities undertook qualitative research in Uganda, where the field of microinsurance is relatively more established than in other countries. Also, since none of the organizations receiving innovation grants from the Bill and Melinda Gates Foundation operate in Uganda, this study avoided the areas from which samples will be drawn for the larger study at a later date.

The study considers two types of insurance: life and health. For life insurance, researchers spoke with clients who were required to buy FINCA Uganda's Group Personal Accident insurance – a type of life insurance policy that also covers some property damage – which FINCA offers through a partnership with the American International Group (AIG). For health insurance, researchers met with FINCA clients who have elected to purchase health insurance through Microcare (an insurance company founded in 2000 targeting the low-income population) and members of Save for Health Uganda (an NGO based in the village of Luwero, located about 50 kilometers north of Kampala). The following are brief descriptions of the participating organizations and their products.

FINCA UGANDA

FINCA Uganda is part of the global FINCA village banking network. Started in 1992, it was the first FINCA village banking program in Africa. In 1998, FINCA Uganda began offering a group accident policy that is required of all borrowers and covers the period of a single loan cycle. The following table summarizes the coverage of the policy.

TABLE 2: SUMMARY OF GROUP ACCIDENT POLICY COVERAGE

In the event of…	The policy provides…
Accidental death of a client	Ush.1,200,000 (US$650) to the beneficiaries and payment of the outstanding loan balance to FINCA
Non-accidental death of a client	Payment of the outstanding loan balance to FINCA
Disability of a client	Payment of the outstanding loan balance to FINCA
Loss of business due to a catastrophe like fire	Payment of the outstanding loan balance to FINCA
Accidental death of a registered spouse	Ush.600,000 (US$300)
Accidental death of a dependent	Ush.300,000 (US$150)

SAVE FOR HEALTH UGANDA (SHU)

Started in 2000 as CIDR Uganda (and managed by the French-based NGO International Centre for Development and Research or CIDR France), Save for Health Uganda consists of groups or associations of 100 to 300 villagers. These groups provide either loans or a mix of insurance and loans to their members through a fund to which the members contribute. Originally, what was then CIDR-Uganda offered two products. One was a mutual health insurance scheme, in which members paid a set premium annually in exchange for health care paid for by their association. The other was an emergency health loan from a fund that members created. It charges no interest for three months. Between the two schemes, the insurance scheme proved more problematic because the insurance funds were often depleted well before the end of the year. Three years after its introduction, SHU decided to drop the insurance-only scheme. Currently, all SHU groups offer the emergency loan, with the exception of three groups that offer a "mixed" product. The "mixed" product is a combination of credit and insurance, with a loan covering the first Ush.30,000 (US$16) of medical costs and insurance covering the balance for expenses between Ush.30,000 to Ush.100,000 (US$54). For this study, researchers conducted focus group discussions with members of both the credit-only and mixed schemes.

IV. Methodology and Data Collection

RESEARCH METHODS

The research used qualitative methods, including focus group discussions, PRA tools, and individual interviews with key informants.

- The researchers used time series analysis to understand how having insurance has changed the way individuals cope with various health risks.
- The researchers used the subscriber satisfaction tool to understand how borrowers subscribed to FINCA's group accident policy viewed the benefit of having insurance tied to their loans.
- A focus group discussion guide was used to probe how individuals cope with risks.

SOURCES OF INFORMATION

Data was generated through focus groups with members of FINCA Uganda, Save for Health Uganda, and two groups of non-members (one rural, one urban). In addition, individual interviews were conducted with four people who have had their claims settled (including the two who received payouts), one of whom was a member of Faulu Uganda. Experts in the field of microinsurance and field officers from both FINCA Uganda and SHU contributed insights as key informants.

SAMPLE DESIGN AND SAMPLE SELECTION

The study involved 14 focus group discussions with a total of 170 participants. Eight groups were organized through FINCA, five through SHU, and one consisting of non-members was convened by the researchers on their own. The participants included a mix of urban and rural residents: all of the FINCA clients plus the group of non-members lived in and around Kampala, while all of the SHU members lived in the village of Luwero and its environs. All the FINCA groups consisted of women; among the SHU groups, there were 26 female and 27 male respondents.

In terms of selection, the researchers sought a mix of policyholders, non-policyholders, and ex-policyholders (drop-outs) of the group personal accident policy in each of the FINCA-organized focus groups. In addition, FINCA offers health insurance through Microcare, which its members can buy voluntarily. In all, 121 FINCA clients (roughly a quarter of whom also had health insurance) participated in the research.

As for SHU, researchers spoke with two groups that subscribed to the credit-only scheme, one group that belonged to the mixed credit-plus-insurance scheme, one group that dropped out of the mixed scheme, and one group of non-members. In total, 53 individuals participated in the research through SHU.

Finally, to ensure that field work covered issues relevant to both types of insurance, the researchers focused on health issues with all five of the SHU groups and three of the eight FINCA groups. They discussed FINCA's group accident policy and ways of coping with various non-health risks with the remaining five FINCA groups and the

one group of non-members that lived in Kampala. Chart 2 summarizes the topics of discussion (group accident/life or health) for the 14 focus groups that participated.

TABLE 3: NUMBER OF FOCUS GROUPS THAT DISCUSSED EACH TYPE OF POLICY/SCHEME

Policy	FINCA	SHU	Non-members	TOTAL
Group accident (life)	5	-	1	6
Health	3	4	1 (organized by SHU)	8
TOTAL	8	4	2	14

TIME FRAME AND LOCATION

This study took place from June 5 to June 16, 2006, with eight days of field work and two days of analysis. The FINCA focus groups were scheduled to coincide with their regular weekly meetings in various locations in and around Kampala, while the SHU groups were specially convened for this research in Luwero.

LIMITATIONS OF THE STUDY

There are several limitations to this study. For one thing, the SHU group-based health scheme is not an insurance product. The study included it nonetheless because SHU provided a set of respondents who were essentially ex-policyholders – a group that would have been difficult to track down otherwise. Additionally, including SHU in the study allowed for a comparison across three different types of health schemes: credit-only, insurance-only (as offered by Microcare through FINCA), and mixed credit-and-insurance. In the end, of the eight focus group discussions that were conducted on health, two had credit-only, three had insurance-only, two (one consisting of current SHU members, the other made up of drop-outs) had the mixed product, and one had none of the above.

Also, as an exploratory exercise, this study seeks to touch upon several different products without going too deeply into any one. As such, the findings presented here are far from definitive. Instead, they only suggest issues that should be addressed more fully in the larger impact assessment.

Finally, the researchers encountered some practical constraints that also limited the study. Originally, 16 focus groups had been scheduled, but one (Save for Health) ended up not meeting and one (FINCA) was canceled due to a scheduling conflict. Because these happened at the last minute, the researchers were not able to reschedule them.

The researchers also tried to interview policyholders or beneficiaries who have received payouts to determine how the lump sums of cash are used by policyholders or their beneficiaries. This presented several obstacles. First, in the case of health insurance, the policyholder or family members do not receive a direct payout; rather, the insurance company directly pays the hospital or service provider. Second, those who had received personal accident insurance payments were very difficult to find. Only a handful of people who were named beneficiaries by FINCA members have actually received money from the insurance policy. These people generally do not belong to FINCA groups and may even live in another town or village, therefore locating them was very difficult. In the end, the researchers were able to speak with only two people who had received payments from the insurance company.

V. Main Findings

In general, the causal pathways and key areas of impact were much easier to identify for health insurance than for group accident insurance. Trying to understand how the latter benefits individuals was more challenging because most of FINCA's clients have never used it. This section presents the key findings of this study.

DIFFERENCES IN KNOWLEDGE AND ATTITUDES

In both types of health schemes studied, the data suggested differences in knowledge and attitude between policyholders and non-policyholders. Those with health insurance, or those who were part of a group-based health scheme, showed a better understanding of health risks and a less fatalistic attitude (see box below). In one SHU group, for example, no member had ever accessed care through the scheme, yet everyone in the group has continued to pay their membership dues for several years running. When asked why they keep on subscribing to the scheme, they listed numerous reasons, including:

- protecting oneself from unforeseen sickness
- not having to pay a lump sum after falling ill but rather being able to pay in small installments beforehand
- being able to access care more quickly
- receiving appropriate care
- wanting to help out others (and liking the fact that they belong to a mutual group)
- being able to leave the home without having to worry about one's family (because other family members will be able to access care even if the breadwinner is not in the home)

In contrast, responses from members of an ex-SHU group that dropped out of a mixed credit-plus-insurance scheme showed a much poorer understanding of both the concept of pooling risk and the scheme itself. The respondents in that group said they wanted more tangible benefits from the health scheme, and noted that other NGOs that work in the area often donate goods and services free of charge. They also said that they couldn't make payments between January and March, which they thought was the only time period allowed for subscription. They were actually mistaken about this fact, as members are allowed to re-subscribe over a longer period.

Religion features prominently in the minds of some Ugandans when asked how they cope with hardships. Without the means to access health care, they rely on prayers. "God is the last resort and [He] usually answers the prayers of those in need," a woman from Kampala explained. "Some time ago, I was bitten by a snake while sweeping my home. I had no money and my husband was away and couldn't be reached by phone. No one could help me, so I just prayed to God and wished for a miracle. I didn't go to a hospital but was healed nonetheless. Our people survive without medicine and God works for them."

Whether the difference in the levels of understanding between these two groups was the result of purchasing insurance (or belonging to a health scheme) is not clear. It's possible that those with a better understanding of health risks were more likely to see the value of paying for health insurance before a crisis struck. It's also possible that those who are most likely to get sick are the ones who choose to buy health insurance. Such self-selection can create tremendous problems for insurers and lead to the collapse of microinsurance schemes.

Belonging to a group like the ones in SHU also seemed to encourage some respondents to feel more comfortable with their HIV status. In one SHU group, several members said that they feel more comfortable identifying themselves as a person living with AIDS (PLWA). They also mentioned that group members are now more likely to get tested and declare their status – a likely result of the better education and greater awareness that they received from SHU. Whether this sense of solidarity extends to other types of health schemes – especially ones that exclude HIV/AIDS from their coverage – is debatable, and this finding may be particular to SHU.

As for the group accident policy that FINCA offers, those who understand and know they're paying for a policy say the biggest benefit comes from not having to worry. The poor face numerous pressures, and hypertension ranks consistently very high on the list of health risks that they face (generally second to malaria). The security in knowing that their loans are covered in the event of a crisis can thus be a major benefit. One woman went so far as to say that she feels like she can now walk "majestically" and confidently, knowing that her family has a safety net should anything happen to her.

Such expressions of appreciation were not common. Because so many of FINCA's members don't fully understand the group personal accident insurance policy, most of them see no benefit in subscribing to it. The finding is not new: previous studies have examined this issue before. What is surprising is how little has changed in the years since this issue first surfaced. The field officers generally don't explain the policy (or maybe they don't explain it well), which can end up hurting their clients. In one group, members recounted a case in which a claim was denied because the name of the deceased on the death certificate did not match the name of the policyholder. According to the members, the woman's maiden name appeared on one and her married name appeared on the other. Apparently, she did not know to change the name on the insurance policy to reflect her new name that resulted from a change in her marital status.

Despite this general lack of understanding, for the few individuals whom researchers were able to identify and who had actually received a benefit from the insurance policy (either in the form of a payout or not having to pay off the debt of a group member who passed away), they were thankful to have had the insurance coverage. A few respondents even expressed an interest in paying for the policy even if it were not tied to a loan. Their exact willingness to pay is unknown, and – as Ronald Zake, a former executive with AIG Uganda who helped to develop the group accident policy, noted – pricing an individual policy not tied to loans may not be feasible because of prohibitively high administrative costs. Nevertheless, the expression of interest demonstrates appreciation and possible demand for the product.

CHANGES IN BEHAVIOR

Those with some sort of health coverage – whether through microinsurance or emergency credit – appeared more willing to seek treatment early and not simply wait to see if symptoms improve on their own (see story of Mr. E. below). Respondents with health coverage also said they were more likely to complete a full

and appropriate course of treatment, as opposed to attempting to treat themselves with painkillers like Panadol (an equivalent of Tylenol), relying on traditional herbs, or not completing a prescribed course of treatment. Without having actually measured time to usage and monitored the treatment of illnesses, this study cannot assess whether these changes in behavior – which were described by respondents in several different groups – are actually true, but the responses suggest that these could be relevant indicators of better health in the long run. In one example, respondents belonging to one SHU group described how they used to not take any preventive measures against dysentery. Since joining the scheme, however, they've learned to boil water and access care at the first sign of ill health. They no longer rely on herbs or "tablets" obtained without a prescription from the local drug store.

When Mr. E. got sick about three years ago, he thought he'd be fine if he just rested for a few days. He was wrong. He ended up bedridden for much longer than he anticipated. During this time, he stopped tending to his business. Even his wife, who normally looks after their small farm, had to stop working and stay by his side. Without any income, his children dropped out of school. In the end, he became so desperate that he finally sold his only cow for a third of what it would normally cost in order to pay for proper health care. By the time he recuperated, he had suffered multiple losses. The experience led him to join an SHU group.

Mr. E.'s membership in a group-based health scheme has changed the way he responds to illness. When he came down with itchy skin rashes more recently, he immediately notified the chairperson of his SHU social group, who provided him with a reference letter for admission to the local hospital. "I was able to seek treatment much earlier, which enabled me to continue working and my children to stay in school," Mr. E. recounted. "Unlike before, I was cushioned on all sides in this case!"

Researchers also probed to see whether having health insurance or some sort of health protection would lead someone to act cautiously or to take on more risk (moral hazard). They found that those with some sort of health protection were generally more likely to take preventive measures like boiling water and clearing out bushes (to reduce the number of mosquitoes around the home). Whether this positive change in behavior is a direct result of the scheme or of something else (like a public education campaign or a better understanding of health risks a priori) is unknown but worth exploring in the larger study. As for instances of riskier behavior, the researchers were not able to identify any. This is not to say that there were none, however; respondents may just have been reluctant to describe negative behaviors. A more careful examination of health behaviors over a longer time frame would be necessary to probe this question further.

As for the group accident policy, researchers found no evidence to suggest that it leads to any sort of behavioral changes. As the insurance policy is tied to loans and is therefore short-term, it did not seem to have any impact on the way people manage their businesses or households.

OTHER AREAS OF IMPACTS (CHANGES IN OTHER VARIABLES)

Those without insurance may lose their assets when hit by a shock. Generally, the first assets to go are livestock or small household items. Those in need of larger sums of money may sell land or furniture and take their children out of school (or rotate them through different schools to avoid having to pay fees). Thus, a major benefit of insurance is the smoothing of household cash flows and consumption. Having

insurance means being able to maintain (or at least not decrease significantly) current consumption levels when a shock hits.

In one example, a FINCA member who had health insurance through Microcare described the help she received after her daughter was hit by a car. The policy covered most of the medical bill (Ush.350,000 out of Ush.400,000, or roughly US$190 out of $216) and she was able to pay the remainder on her own. Despite the financial help, she still had to take time away from her business to take care of her child, thereby reducing her income over a three-month period by more than 65 percent. During this period, her other children ate and slept less, yet she is still very grateful. "If I had to foot the entire bill, I would've lost my business entirely," she said. "I earned less than what I would normally earn, but [what I did manage to earn] was still a big benefit."

The example illustrates how insurance seldom covers the full cost of the losses. It can reduce the severity of the negative shock, but it cannot eliminate it. To assess the impact of insurance, one must measure the size of the reduction.

Aside from helping to maintain current consumption levels, health insurance – and even interest-free credit for health purposes – can improve a household's ability to withstand shocks by giving it more time to cope. People are less desperate when they have some sort of cushion to fall back on, such that even if they end up having to sell an asset, they wouldn't have to sell it immediately and at discount. They could at least wait a bit and look for the highest bidder.

The original causal model had also considered the possibility that having insurance would encourage people to pursue and engage in economic activities that involve higher risk but also have the potential for greater financial returns. There was no evidence to suggest that this is the case, and one would not expect to see an increase in revenue generation at the enterprise level as a result of having health insurance. At best, one is able to maintain current enterprise performance in the event of a shock.

This is not to say that one would not expect to see impact at the enterprise level, however. Indeed, being able to maintain current levels of performance in the face of a health shock is a major benefit of these health schemes, and one would expect to see the survival rate of businesses to go up in the long run. This benefit, in turn, transfers to the household level, as well. With the breadwinner able to continue earning, the household is able to maintain its consumption levels and finds less need to pull its children out of school.

As for the group accident policy, maintaining other members' ability to keep borrowing even after the death of a member or property loss (which the policy also covers) is a major benefit. Members of a group in which five members had their businesses destroyed by fire explained how they were able to rebuild because their previous loans were paid off and they could borrow again. In another instance, a young man was able to get a much-appreciated financial boost from the insurance company after his mother died and he was forced suddenly to become the chief breadwinner of his family (see box below).

Twenty-eight-year-old Mr. S. lost his mother in 2003 when she was hit by a speeding car. Because his mother was a member of FINCA and had a personal accident policy, Mr. S. received Ush.1,000,000 (roughly US$540) a few months after his mother's FINCA group helped him to file a claim. He had been a student at the time of his mother's death, but as the new head of a household in charge of three younger siblings (his parents had been separated and his father had left the family years before), he decided to leave school in order to start a motorcycle taxi service (boda-boda). With the money he received from the insurance policy, he paid off the outstanding Ush.200,000 (US$108) balance on school fees for his brother and two sisters and put down a deposit of Ush.700,000 (US$378) on a motorcycle that costs Ush.1,400,000 (US$756). He used to the remaining Ush.100,000 (US$54) to pay for a license and a "stage" (or curb-side stopping area) where he can solicit passengers. According to Mr. S., "[running a taxi service] is a challenge. The motorbike sometimes breaks down. I can pay for its maintenance because my mother had built our house and I don't have to pay for housing. Our grandfather also contributes to my brother's school fees, so we manage."

The fact that Mr. S. was able to receive a lump sum of money that he could not have otherwise is significant. Without having built up his own creditworthiness, he was able to obtain one million Uganda shillings (or roughly US$540) for buying productive assets. What's more, he was able to pay off the debt in school fees. The overall impact of this payout on the household is unclear, but Mr. S.' story suggests that the insurance allowed his family to purchase assets that it otherwise would not have been able to get. In a similar case, a young man whose daughter had died diverted money away from funeral expenses and saved the lump sum for a future purchase. Both of these stories suggest that payouts – when they do get paid – can have a significant impact on the wellbeing of individual households. Whether they have an effect at a more aggregate level is uncertain, given how rarely FINCA Uganda actually disburses them.

Ms. B.'s daughter was only one-and-a-half years old when she succumbed to measles. Fortunately, Ms. B. – who is 23 and runs a small dairy and a motorbike taxi service – is a member of Faulu Uganda, an MFI that offers a similar credit/life insurance product through a partnership with Microcare. Unlike the product offered by AIG, this one provides a payout to policyholders even in the event of natural death, and Mr. B. received Ush.300,000 (US$162) as a result of losing his child. The money is intended to cover funeral expenses, but because he didn't receive payment until nearly four months after his daughter's death, he borrowed Ush.100,000 (US$54) from friends and neighbors. By the time he received money from the insurance company, he had already paid off his debt through working. For now, he has put the money in a savings account, which he has earmarked for the purchase of a newer motorcycle to replace his older one. He says he is very grateful for the insurance benefit, even though it was late, and adds that he'd consider paying for a policy even if he didn't have a loan through Faulu.

Finally, the effect of having insurance on the use of other coping mechanisms varied between the two types of schemes. For the group accident policy, the researchers found no data to suggest that FINCA clients changed the way they use other strategies for dealing with risks. Many still maintain other ways of ensuring protection for their families, such as keeping livestock on hand, running side businesses, taking on extra contractual work, and – in the case of one group whose members were well-to-do enough to own some land – building rental units. Given the fact that the policy is

short-term and tied to loans, and the fact that some of the clients are not aware of the policy, this finding is not surprising.

As for those with health coverage, either through a group-based non-insurance scheme or through health insurance, the results show more positive changes. In general, there was evidence to suggest that having insurance leads individuals to rely less on ex post strategies for dealing with a health shock. For example, in one group of FINCA clients who all had purchased Microcare's policy, the women described how they now take more preventive measures, like boiling water, using bed nets, and clearing up bushes from around their homes. In another FINCA group, several respondents said that they get sick less often as a result of having insurance (possibly due to greater use of preventive measures or seeking treatment earlier). Several groups mentioned not having to borrow money (or at least not as much) from friends and families. Some of these changes may be the result of other interventions (e.g. a health education campaigns that advocates the use of bed nets), so whether all of the positive changes observed can be attributed to health coverage is debatable. Given these preliminary findings, however, this is an area in which one could see major impact.

VI. Conclusion

This study sought to identify and refine the causal pathways and indicators for understanding the impact of microinsurance on the poor. The task proved to be much simpler for one type of insurance than for the other. For health insurance, the study was able to refine the original chart and suggest a few additional indicators that could be used in a longer-term impact assessment (see Chart 2 and Table 2 below). Namely, the revised causal model identifies the following causal pathways to impact:

- The most immediate benefit of health insurance is a greater sense of security, which can lead to less hypertension and, presumably, better health.
- Having health insurance leads individuals to seek treatment earlier and complete full courses of treatment, which may lead to an improvement in the overall health of the population at the community level.
- Health insurance may also contribute to an increase in the survival rate of business by improving the health of individuals and reducing their likelihood of having to take time away from work due to sickness.
- Finally, health insurance can benefit the household by reducing the negative impact of health shocks, such that families can maintain their current consumption levels and keep their children in school.

FIGURE 2: IMPACT CAUSAL MODEL OF HEALTH INSURANCE

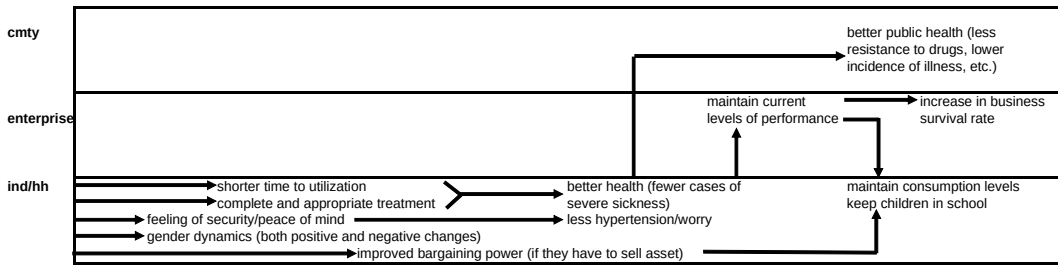


TABLE 4: FRAMEWORK FOR ASSESSING THE IMPACT OF INNOVATIONS IN INSURANCE

Level of Analysis	Domains of Impact	Intermediate Indicators	Final Indicators
Individual	Individual health	Shorter time to utilization of health services Complete/appropriate treatment	Fewer incidences of sickness
	Self esteem	Feeling of security/place of mind	Less worry/improves self-esteem
Household	Household consumption	Maintain ability to work when sick Better able to sell assets (fetch better price)	Maintain consumption levels Keep children in school
Enterprise	Enterprise performance	Maintain current levels of performance	Increase in business survival rate
Community	Public health		Improved public health

For the group accident insurance, the study was not able to refine the causal model as much, given the limited usage and understanding of current clients. The different experiences in studying the two types of insurance speak to the importance of understanding the product parameters and how they determine the impact causal pathways. Not all microinsurance products are the same, and depending on the details, the indicators used to measure their impact will vary. Having said this, there are a few general conclusions that this study draws.

The causal pathways and impact of microinsurance are considerably more nuanced than those of micro-credit or micro-savings, in a way that indicators used to measure the impact of micro-credit and micro-savings probably do not apply. Different indicators and more creative ways of measuring changes in those indicators (likely to involve qualitative methods) will be necessary to understand whether and how microinsurance makes a difference in people's lives.

Take the case of someone who, even with insurance, ends up having to sell an asset like a cow to cover medical costs. Simply observing the sale could lead one to believe that the insurance had very limited impact, since the household lost an asset regardless. Yet it's very possible that, had the person not had insurance, she would have had to sell it at a discount. The difference between what she would have lost, versus the lesser amount of the actual loss that she incurred, is the positive impact of having insurance. Current measures of impact for microfinance do not consider this difference.

Another difference between microinsurance and other kinds of microfinance products is the former's impact on behavior and attitudes. Based on this preliminary research, this is probably the most robust area of impact, yet changes in behavior and attitudes can be extremely difficult to observe. For example, a major benefit of insurance is the sense of security that people have in knowing that they and their loved ones are covered in the event of a major shock, but this sense of security does not manifest itself in any directly observable way.

Fortunately, there are other changes that may be much easier to measure, such as the shorter amount of time to accessing health care and the ability and willingness to complete a full and appropriate course of treatment. Changes in a person's willingness to seek preventive care or get tested for HIV/AIDS may also be readily observable. These changes are likely to occur within the few years of subscribing (or belonging) to a scheme, suggesting that "seeking treatment earlier" and "completing full and appropriate course of treatment" could be useful intermediate indicators in measuring impact on individual health.

Yet another difference between microinsurance and other kinds of microfinance products is the importance of knowledge. The fact that FINCA's group personal accident insurance is a mandatory policy means that many borrowers don't know or don't fully understand that they have it. This lack of understanding, in turn, can limit the amount of benefit that they receive. If one is not aware of the fact that she has this insurance, she derives no "peace of mind" from it. What's more, she may not even know to make a claim when someone in her family dies. In other words, whether impact is achieved may depend on a client's awareness and understanding of insurance.

Finally, as a first step in trying to understand the impact of microinsurance, this study directs future research by raising new questions. The following section highlights several key areas for further investigation.

VII. Further Research Questions

How important is use of payouts to understanding impact?

In this study, payouts were irrelevant to both health insurance schemes, which – like many other health insurance schemes – send payments directly to the health service provider. As for their relevance to the group personal accident policy studied, they affect only a very small number of FINCA clients: for each of the past three years, the number of settled claims averages less than one tenth of one percent of the total number of clients, and only a fraction of those settled claims actually involved a payout. As such, the real impact of microinsurance may not lie in the actual use of funds given, but in behavioral or attitudinal changes that occur as a result of having insurance. This observation may not hold for other microinsurance products, however, depending on how they are designed. Future research could look more closely at whether payouts actually matter at the aggregate level.

Does having health insurance – and with it, greater access to health care – affect one's willingness to pursue new economic opportunities?

One of the key questions posed by this study was whether impact occurs at the enterprise level. The data showed that microinsurance does have an impact at the enterprise, but only insofar as its ability to minimize losses after a shock. The researchers did not observe or hear about anyone pursuing new opportunities as a result of having insurance. Nevertheless, it's possible that – given the security and the greater access to care that health insurance appears to provide – individuals who previously would have avoided new ventures would become more willing to pursue them after joining a scheme. In the SHU group-based schemes, for example, some of the members described how people living with AIDS are now more comfortable with their HIV-positive status and have a more confident outlook on life. Whether this greater level of comfort and newfound confidence leads to higher productivity among this group is a question worth examining.

How do gender dynamics affect impact at the household level?

In Uganda, it is not uncommon for men to take on several wives. When this happens and the man abandons some of his financial obligations to his family, the net impact on the household is uncertain. It's possible that, through membership in a health scheme like SHU's, a woman simply takes over the financial obligations that her husband used to have and there is no overall change in the welfare of the household. In two separate groups, women talked about how their husbands have either become lazier or abandoned the family altogether after seeing their wives take greater control over the household and obtained protection for their families through insurance and other mechanisms. Some of the women even suggested that others "divorce the lazy man" and "don't mind the lazy husband and concentrate on your own work."

It's also possible that, by extending the family, the benefits also spread to other individuals. In one example, a woman belonging to one of SHU's social groups described how her husband used to complain about her membership. He simply didn't see the point, at least not until he fell sick one day and required an operation. Her membership paid for his procedure, and he became so impressed with the scheme that he eventually convinced his other wives and their children (who weren't even his) to join the scheme as well.

Can we expect to see community-level impacts, and when could we expect to see them?

If having health insurance encourages people to seek treatment earlier and follow appropriate courses of treatment, one would expect that the community as a whole would benefit, especially with regards to communicable diseases. Whether such a community-level impact resulting from health insurance (and with that, greater willingness to access care) actually translates into greater welfare for everyone – and when that would occur – is unknown. The time required for community-level impacts to appear is likely to exceed the five-year time frame that the Bill and Melinda Gates Foundation is currently considering.

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